

Husbands' experiences and perceptions regarding the use of maternity waiting homes in rural Zambia

Citation for published version (APA):

Sialubanje, C., Massar, K., Kirch, E. M., van der Pijl, M. S. G., Hamer, D. H., & Ruiter, R. A. C. (2016). Husbands' experiences and perceptions regarding the use of maternity waiting homes in rural Zambia. *International Journal of Gynecology & Obstetrics*, 133(1), 108-111. <https://doi.org/10.1016/j.ijgo.2015.08.023>

Document status and date:

Published: 01/04/2016

DOI:

[10.1016/j.ijgo.2015.08.023](https://doi.org/10.1016/j.ijgo.2015.08.023)

Document Version:

Accepted author manuscript (Peer reviewed / editorial board version)

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Download date: 05 May. 2023

1 **Husbands' experiences and perceptions regarding utilisation of maternity waiting**
2 **homes in rural Zambia**

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18 **Synopsis:** Husbands perceive many benefits from use of MWHs. However, various
19 challenges affect their wives' use of MWHs. Mitigating these could improve access to
20 facility-based delivery.

21 **Key words:** maternal health, maternity waiting home, Kalomo, Zambia. **Word count:**
22 **2,649**

1 **Abstract**

2 **Objective**

3 To explore husbands' beliefs and **roles** towards utilisation of maternity waiting homes
4 (MWHs) in Kalomo district, Zambia.

5 **Methods**

6 We conducted a qualitative study using in-depth interviews (st April to 31st May, 2014) to
7 explore husbands' perceptions and roles regarding utilisations of MWHs. The inclusion
8 criteria comprised being aged between 18-50 years, and being married to a woman of
9 reproductive age.

10

11 **Results**

12 24 husbands were interviewed in 7 rural health centres with MWHs. They perceived
13 many potential benefits from using MWHs including **improved** access to facility-based
14 skilled delivery services and treatment **in case of labour complications**. Their many roles
15 **included** decision-making, finding money for transport, food and buying cleaning
16 materials and clothes for the mother and the baby to use during and after labour.
17 **However**, limited financial resources made it difficult for them to provide for their wives
18 and **babies** and usually led to husbands' delay in making decisions for their **wives'** use
19 **of** MWHs. Further, poor conditions in MWHs and the lack of basic social and healthcare
20 needs in MWHs made some husbands forbid their wives from using the MWHs **facilities**.

1 **Conclusion**

2 These findings suggest important intervention targets for improving access to MWHs
3 and skilled birth attendance.

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1 Introduction

2 Many women in rural Zambia do not receive assistance from skilled birth attendants [1-
3 3] due to **limited** access to health facilities and pregnant women have to walk long
4 distances to reach them [4-11].

5 To increase access, maternity waiting homes (MWHs) have been established in many
6 developing countries, including Zambia [12,13]. The World Health Organisation (WHO)
7 has defined MWHs as “residential facilities, located near a qualified medical
8 establishment, where women with high-risk pregnancies can wait for their delivery and
9 be transferred to a nearby medical facility shortly before delivery, or earlier, should
10 complications arise” [12].

11 **Currently, evidence to support the effectiveness of MWHs to** increase access to skilled
12 care for populations living in remote areas or with limited access to services is low [14].
13 However, **studies conducted in developing countries suggest that MWHs could help**
14 **improve maternal and newborn health outcomes [13, 15-17].** For example, in Ethiopia,
15 Kelly et al [16] reported that women attending MWHs before hospital admission had
16 lower maternal mortality rates and stillbirths compared to those who were directly
17 admitted to a hospital.

18
19 Moreover, studies show that women have a positive attitude towards MWHs **[15, 18].**
20 Nevertheless, utilisation of MWHs is still low in most developing countries **[13, 15-19]**
21 due to various reasons including lack of financial resources for use while staying in the
22 MWHs and women’s lack of decision-making autonomy **[18, 21-23].** For example, a

1 study in Ghana [20] reported that women could only use facility-based delivery services
2 if they obtained permission from their husbands. Moreover, Mpembeni et al [22] showed
3 that single Tanzanian women with some financial autonomy were more likely to use
4 institutional delivery services than married women.

5 There is a lack of evidence on husbands' perspectives and their role in supporting their
6 families to seek healthcare services. One qualitative study conducted in Egypt [23]
7 involving women of reproductive age, men and old women showed that husbands
8 played an important role in supporting their families and helping their wives in seeking
9 healthcare services.

10 The aim of this study is to explore husbands' experience and beliefs about their role as
11 decision-makers, providers for their wives' healthcare needs during pregnancy and
12 childbirth, and utilisation of MWHs. This understanding is important as it will provide a
13 starting point for interventions focusing on improving utilisation of MWHs and facility-
14 based skilled delivery services in rural Zambia.

16 **Materials and Methods**

17 This qualitative study was conducted in Kalomo district, Zambia. The Tropical Diseases
18 Research Centre Ethics Review Committee and the Ministry of Health Research and
19 Ethics Committee in Zambia granted ethical approval.

1 The district has an estimated population of 275, 779 with an annual growth rate of 4.4
2 %. The district has two first level referral hospitals, thirty-four health centres and several
3 health posts. Of the 34 health centres, only ten have MWHs.

4
5 Study participants comprised husbands purposefully selected from 7 health centres with
6 MWHs using multi stage convenience sampling. First, all the 10 health centres with MWHs
7 in the district were identified. Second, senior health officers in-charge these centres
8 were contacted regarding the purpose of the study. They were also asked to inform
9 mothers about the study during the under five clinic. Next, mothers were advised to
10 inform their husbands about the study and ask them for possible participation..
11 Husbands who were willing were asked to come to the clinic with their wives during their
12 next under five clinic visit.

13 Convenience sampling was used in order to increase the chances of selecting husbands
14 who met the inclusion criteria. For eligibility, husbands should be aged 18- 50 years,
15 married to a woman of reproductive age (i.e. aged 15-45 years) who had given birth
16 within the last year- either at the clinic or at home- and have resided in the area for
17 more than six months. Those who had lived in the district for less than six months were
18 excluded because the investigators thought these husbands would not have had
19 enough local experience on MWHs and facility-based delivery in the area.

20 Furthermore, a multi stage convenience sampling technique was used to select
21 respondents from different health centres, villages and families which, in turn, would
22 allow researchers to elicit and encounter as many different views as possible from the

1 selected respondents. This would provide a holistic investigation of differences in beliefs
2 and roles based on their experience with the MWHs. This, in turn, would provide in-
3 depth insight into the subject under investigation [24].

4 Interviews were conducted in Tonga by two trained research assistants outside health
5 centre premises, normally under the shade of a tree. To ensure privacy and
6 confidentiality, each IDI was conducted in a quiet place, and lasted between 30 and 50
7 minutes.

8 Before each interview, written consent was obtained from participants by requesting
9 them to read and sign the consent form, which was translated into Tonga. Next, each
10 respondent was asked to complete a short demographic questionnaire. For those who
11 could not read, research assistants read the consent form and the questionnaire and
12 filled it in. One research assistant conducted the interview, while the second one
13 recorded the session using a digital voice recorder.

14 A semi-structured interview guide, translated into Tonga, was developed based on a
15 literature review and researchers' experiences and findings from their previous studies
16 in the area [5,6,18]. Husbands' perceptions on the perceived benefits, decision-making
17 process, perceived barriers, and the husbands' roles in their wives' use of MWHs, were
18 explored.

19 A total of 24 IDIs were conducted with husbands in 7 health centres with MWHs. After
20 this number, data saturation was achieved; that is, no more substantial information, and

the research team decided to stop the interviews and, thus, leave out the remaining three selected clinics.

Voice recordings were transcribed and translated into English by research assistants. To check for accuracy, a few transcripts (20%) were back-translated into Tonga. Research team members then compared the Tonga and English versions for differences and similarities while listening to the original voice recording. Each transcript was then thoroughly read by one research assistant while the other one was listening to the corresponding voice recording. After proof-reading and corrections, transcripts were saved on a password-protected computer and later exported into Nvivo10 MAC for processing. Data were then coded and categorised. An inductive approach was used to identify the key themes by content-analysing and grouping all the similar statements made with respect to particular themes. Demographic information for the respondents was analysed using descriptive statistics in IBM SPSS Statistics 21.

Results

Table 1 summarizes the demographic characteristics of the 24 (n=24) respondents included in the study.

Perceived benefits

Most husbands perceived many benefits from using MWHs. They believed that MWHs increased access to facility-based skilled birth assistance and mitigated long distances and transport costs to health facilities. Staying in the MWHs made it easy for pregnant women to walk to the clinic to see the nurse or midwife as soon as they knew they were

1 in labour. Moreover, nurses and midwives would easily identify women with high risk of
2 labour complications and provide treatment in time. Those with complications would be
3 referred to the district hospital for further management and care.

4 *“The mothers' shelters provide a lot of benefits for the mother and the child, because it*
5 *will be easy for them to walk to the clinic and tell the nurses that they need help” (39*
6 *year old husband)*

7 Further, husbands indicated that MWHs provided accommodation facilities which made
8 it easy for pregnant women to go with an accompanying family member and some of
9 her small children if she had no one to leave them with at home.

11 ***Perceived barriers***

12 In contrast, most husbands mentioned that their wives did not made use of the MWH
13 during their last pregnancy. The main barriers that affected the decision to use MWHs
14 were the lack of funds for food, cleaning materials and clothes for the mother and baby
15 needed during and after labour. Husbands believed that health centre staff would refuse to
16 attend to their wives if they did not take the necessary requirements. Consequently,
17 those who failed to find the required resources either delayed making the decision to
18 allow their wives to use MWHs or did not allow them at all.

1 *“The main challenge being faced by husbands in this community is lack of money. Most*
2 *of the times women don’t come to the mothers’ shelter to wait for delivery because their*
3 *husbands fail to provide them with food and other requirements” (36 year old husband)*

4 The other barrier affecting utilisation of MWHs was the poor and deplorable state of the
5 MWHs. Most lacked basic social services such as sleeping space, beds, mattresses, blankets
6 or beddings, water and toilets, as well as good sanitary conditions.

7 Furthermore, poor quality of healthcare services at the MWHs was another important
8 barrier to the use MWHs. Husbands who believed that healthcare staff did not conduct
9 regular visits to check on pregnant women’s conditions while they were staying in the
10 MWHs did not allow their wives to use MWHs. In addition, lack of an ambulance at the
11 health centre discourage husbands from allowing their wives to use MWHs. Husbands
12 believed health centres did not have ambulances; they depended on the one from the
13 district hospital which took long to arrive at the health centre when needed and women
14 with complications had to be transported for long distances on bad roads.

16 **Decision-making**

17 The decision-making process regarding utilisation of MWHs mainly involved the husband and
18 wife sitting down to discuss preparations for the baby and whether the woman should go to the
19 MWH or not. However, the final decision was made by the husband after taking into
20 consideration potential risks of labour complications if the woman delivered at home, the
21 benefits of using MWHs and giving birth at the clinic, as well as the factors that would make
22 it difficult for the wife to use the MWH such as lack of funds for food and other requirements to

1 use at the MWHS, poor state of and services in MWHS, and failing to find a family member to
2 remain with the children at home. Husbands who perceived these barriers did not allow their
3 wives to use MWHS.

4 *“We sit down with my wife and discuss the issue at hand and agree. I advise her*
5 *that now that you are approaching, you have to stay at the mothers' shelter” (39*
6 *year old husband)*

“I am the one to decide. Since it would lessen my burdens, I would allow my wife
to go and stay at the shelter” (28 year old husband)

7 Moreover, some husbands indicated that they allowed their wives to make the final decision and
8 that some women made the final decision. For unmarried women, parents made the final
9 decision, while sisters, mothers, mothers in- law and grandmothers played an important role in
10 case of young couples. In contrast, some husbands argued that they consulted friends and
11 neighbours.

12 ***Husbands' roles***

13 The husbands' major roles and responsibilities included making the final decision on the
14 use of MWHS, finding money for the things that were needed during and after labour
15 including cleaning materials and clothes for the mother and baby, and to ensure
16 availability of enough food for the wife and accompanying relatives staying at the MWH.
17 Moreover, the husband had to take care of the children together with one of the
18 assigned family members.

1 *“His duty is to make sure that he provides everything. He is the one to buy*
2 *everything that the mother and child will need until she delivers and goes back*
3 *home” (27 year old husband)*

4 **Discussion**

5 The aim of this study was to explore husbands’ experiences and beliefs regarding
6 utilisation of MWHs in Kalomo, Zambia. Overall, our findings show that husbands had a
7 positive attitude towards MWHs and perceived benefits from using this service including
8 mitigating long distance and improving access to facility-based delivery services.
9 However, several challenges including a lack of financial resources and concerns about
10 the availability and quality of social and medical services in the MWHs made it difficult
11 for most husbands to support their wives to use the homes.

12
13 Husbands believe that MWHs are an important means to improving access to skilled
14 and facility-based delivery and to prevent complications during labour and delivery.
15 Their main role during pregnancy and childbirth mainly consists of making the final
16 decision on the wife’s use of MWHs, providing money for food, transport and buying
17 cleaning materials and clothes for the mother and the baby, and finding someone to
18 take care of the children in the wife’s absence. These findings are in line with our
19 previous research [18] and a study from Egypt [23] which reported that husbands
20 played an important role in providing for their wives during pregnancy and childbirth,
21 and in encouraging them to use health services.

1 In contrast with previous studies [5, 18, 20-22,25] which suggested that husbands'
2 decision-making role posed important barriers to women's use of facility-based delivery
3 services, our findings show that husbands play an important role in fostering women's
4 health seeking behaviour. Interestingly, although, husbands often make the final
5 decision whether or not the woman should use the MWHs, they do not make decisions
6 unilaterally. Rather, the decision-making process involves the husband and wife sitting
7 down together and discussing preparations for childbirth, taking into consideration
8 several factors including potential risks of labour complications if the woman delivered at
9 home, and benefits of using MWHs and giving birth at the clinic. Moreover, some women
10 made the final decision and only informed the husbands about it. Furthermore,
11 decisions were made in consultation with family members. This finding is consistent with
12 our previous findings [18] and those of other studies outside Zambia [23] which showed
13 that maternal health issues were often discussed by husbands and wives.

14 Consistent with previous studies from Zambia [2,5,6,7] and other developing countries
15 [21,22], our findings show that most respondents' wives did not use the MWHs during
16 their last pregnancy due to various reasons including ~~Moreover, when MWHs were~~
17 ~~available, both husbands and wives expressed a negative attitude due to their~~ the
18 perceived poor state and low quality of services ~~non-availability of MWHs in some~~
19 ~~health facilities and~~ in the MWHs, nonavailability of nurses and midwives to monitor
20 pregnant women's conditions to ensure their medical safety when staying in the MWHs.
21 ~~Moreover, when MWHs were available, both husbands and wives expressed a negative~~
22 ~~attitude due to their perceived poor state and low quality of services~~. Consequently,
23 couples that were not satisfied with the quality of services in the MWHs did not use the

1 service. These findings are in line with our previous study [18] and other studies
2 [2,5,6,7,21-22] which reported low utilisation of MWHs, mainly because of their poor
3 state and a lack of basic social and medical services.

4
5 Moreover, most husbands faced several important challenges, such as a lack of
6 financial resources which made it difficult for them to provide for their wives intending to
7 use the MWHs. Consequently, husbands that failed to find requisite funds often did not
8 allow their wives to use MWHs; some delayed making the decision for their wives to
9 leave home to the last minute. This finding is in line with previous studies
10 [2,5,6,19,20,25] which reported that a delay in decision-making at the family level was
11 one of the important factors negatively affecting utilisation of various maternal
12 healthcare services. In addition, this result stresses the importance of economic factors
13 in influencing decisions regarding use of healthcare services [2,5,6,7,15, 21,22].

14 Some potential limitations of our study should be noted. First, these findings are only
15 based on the experiences of the IDI respondents from the health centres with MWHs
16 who came to use under five clinic services; experiences of husbands who did not utilise
17 the services and those from the health centres without MWHs were not explored. Thus,
18 these results may not be applicable to the individuals from communities/districts where
19 MWH are not available.

20 However, the current findings highlight the important barriers husbands perceive
21 including lack of financial resources, poor quality of the MWHs and the low quality of
22 healthcare services and medical safety for pregnant women staying in the MWHs. These

findings suggest important intervention targets for improving access to MWHs and skilled birth attendance in rural Zambia.

Acknowledgements

This work was supported by the Netherlands Organisation for International Cooperation (Nuffic) as part of the first author's PhD scholarship, PhD/367.

Conflict of Interest

All authors declare there are no conflicting interests.

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